State of Connecticut
Department of Developmental Services
Investigation Report

Client Name: **Incident Date:**

Abuse/Neglect Investigation Review

Client Name Qualified Provider/Vendor	Report Date	Allegation Type	Qualified Provider/Vendor Findings	DDS DOI Review
				☐ **Agree** ☐ **Disagree**

If applicable, please note the following:

☐ Specific nature and extent of assistance by the DDS DOI to the qualified provider/vendor in the completion of this investigation:

Explanation of modifications made to the components of the investigation submitted by the qualified provider/vendor:

- ☐ Page(s):
- ☐ Signature(s):
- ☐ Statement(s):
- ☐ Documentation to support findings:
- ☐ Findings/Summary:
- ☐ Other:

If applicable, specific rationale for disagreement with the findings of the qualified provider/vendor:

_____ _____

DDS Lead Investigator Signature **Date**

I agree / do not agree [circle one] with the DDS Lead Investigator, and recommendations.

_____ _____

DDS Regional Director/Designee **Date**